Michigan Quality Improvement Consortium

TREATMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) FOR CHILDREN AND ADOLESCENTS

The following guideline recommends treatment procedures for attention-deficit/hyperactivity disorder.

Eligible Population	Key Components	Recommendation and Level of Evidence
Children and adolescents diagnosed with ADHD	Age-specific general recommendations	ADHD is a chronic condition, and therefore, its management should follow the principles of the chronic care model and medical home **[B].** ◆ Treatment includes addressing co-morbid conditions, including substance use **[B]**. Consider referral to a specialist. **Recommendations vary by age**: **Age < 4 years old, refer to a specialist.** **4-5 years old:** First line treatment: evidence-based parent- and/or teacher-administered behavior therapy **[A]**. Medication should only be prescribed if moderate to severe symptoms persist or if behavior interventions are not available and harm of not prescribing outweighs the risks of starting medication at an early age **[B]**. **6-11 years old:** First line treatment: FDA-approved medication for ADHD **[A]** and/or parent- and/or teacher-administered behavior therapy, preferably both **[B]**. **12-18 years old:** First line treatment: FDA-approved medication for ADHD **[A]** and/or behavior therapy **[C]**, preferably both.
	Non-pharmacological treatment and education	Behavior therapy **[A]** Co-interventions which could ameliorate psychosocial, family or academic co-morbidities of ADHD: family and patient education[1], training in anger management and impulse control, cognitive training, school programming and supports, support groups and organizations, i.e. Children and Adults with Attention Deficit Disorder (CHADD)
	Pharmacotherapy	For patients in whom pharmacotherapy is indicated, consider trial of psychostimulants starting with a low dose of a preparation with a short half-life and increasing weekly or biweekly **[B]**. Titrate to clinical improvement or stabilization at the lowest dose necessary. Follow-up with the prescriber within 2-4 weeks after starting a psychostimulant and at least two more times within the first 9 months of treatment. Monitor for side effects, including, but not limited to: weight loss, growth deceleration, adverse cardiovascular effects, insomnia, depression, psychosis, or tics. After effective dose is known, transition to a longer-acting agent may occur if desired. Response to one psychostimulant does not predict response to another **[A]**. For patients who have no response or have significant side effects consider trial of non-stimulants, or referral to a specialist. If suspicious of misuse and/or diversion, consider obtaining a MAPS[2] report or urine drug screen.

[1]The American Academy of Pediatrics recommends using its **ADHD toolkit** and stocking the office with questionnaires, diagnostic checklists and patient education materials

[2]**Michigan Automated Prescription System (MAPS)**

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on The American Academy of Pediatrics ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management; Pediatrics 2011;128;1007. Individual patient considerations and advances in medical science may supersede or modify these recommendations.